

MDS 3.0 Section Q Referral / Roles and Responsibilities, NFs, SLRC (LCA), and GSIL

Nursing Facility (NF)

1. Administers MDS 3.0 Section Q at the frequency and manner as directed by CMS.
2. Transmits referral to local ServiceLink Resource Center (SLRC), the Local Contact Agency for MDS 3.0 Section Q Referrals within 3- business days of resident responding “Yes” to Q 0500.
 - a. Documents in resident’s Medical Record if referral is not made to LCA within 3 business days of resident request.
3. Within the same 3-business day period, NF provides resident with SLRC brochure to inform him/her who will be coming to visit to talk about community living options.
4. Engages in discussion as needed with SLRC.
5. Maintains collaboration between facility and SLRC to support residents expressed interest in being transitioned.
6. Coordinates with SLRC and resident to arrange fact to face visit.
7. Supports the resident in achieving his or her highest level of functioning by participating in conversation with the individual, family (circle of support), and SLRC to learn if individual wants to move forward or end referral process.
8. If already receiving Medicaid funded LTC, a **change of status form** should be sent to BEAS. The information provided by BEAS will be a tool for coordinating potential transition to community through the Community Passport/ Money Follows the Person Program.
 - a. Refer to NHPCT/ Section Q Reference Manual for Community Passport/Money Follows the Person program description/details
9. **Submits** referral(s) to community provider(s) (chosen by the resident), coordinates and assists community support provider(s) as needed to facilitate a transition to the community.
10. Documents in resident’s Medical Record all Section Q activities and actions taken by the NF and resident’s decision regarding their transition to community.
11. Per facility protocol, executes follows-up practice with individual after discharged into community living
12. Adheres to confidentiality and Health Insurance Portability and Accountability Act requirements.
13. Participates in available training pertaining to the NHPCT/Section Q Referral Process for New Hampshire.

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ServiceLink Resource Center Network (SLRC), Local Contact Agency (LCA) –First Point of Contact for Section Q Referrals

1. Confirms with the nursing facility receipt of referral notification document, confirms interest with both resident and facility by making a telephone contact to resident or residents preferred contact, and schedule an appointment with the resident, within 3 business days of receiving referral. *
2. Documents in Refer 7 (in accordance with Refer 7 Section Q Guidelines), that a Section Q referral notification received from NF.
 - a. Establishes file for referral notification.
 - b. Documents if timeline not met for confirming receipt of referral, confirming interest and scheduling appointment with the resident.
3. Refers to GSIL for consult as needed.
4. Conducts face to face visit, with the individual and informs him/her of community living options
 - a. Document in refer 7 (in accordance see # 2) if face to face not conducted within 10 working days of receiving referral.
5. Informs NF that face-to-face visit has occurred and information about community living options has been provided to the resident.
6. Coordinates with NF (and other team members as necessary) to explore community care options/supports. Provides information on these options as needed.
7. Participates in conversation with the resident, family (circle of support), and NF to learn if resident wants to move forward or end referral process.
8. Assesses resident for potential eligibility for Community Passport /Money Follows the Person Program
 - a. Refer to NHPCT/Section Q Reference Manual for Community Passport/Money Follows the Person Program description/ details.
 - b. If additional information is needed, contacts Community Passport/Money Follows the Person Program directly.
9. Supports nursing facility in conducting appropriate care planning to determine if transition back to the community is possible.
10. Refers to GSIL for additional consult (if needed) and /or Transition Coordinator based on the GSIL Nursing Facility Transitions and Life Skills Training Program.
 - a. Refer to NHPCT/Section Q Reference Manual for Nursing Facility Transition program details.
11. Documents in Refer 7 (in accordance see # 2) all Section Q activities and actions taken by SLRC and resident's decision regarding their transition to community.
12. Adheres to Confidentiality and Health Insurance Portability and Accountability Act requirements.
13. Participates in available training pertaining to the *NHPCT/Section Q Referral Process for New Hampshire.
***The level and type of response needed by an individual is determined on a resident-by resident basis.**

Granite State Independent Living, Inc. (GSIL) Consultant to Service Link Resource Center Network for Section Q Referrals

1. Serves in consulting role for SLRC through the referral process as needed.
2. Provides SLRC, resident and family (circle of support) with additional information as needed.
3. Responds to referrals for consult and /or to participate as Transition Coordinator based on the GSIL Nursing Facility Transitions and Life Skills Training Program.
 - a. Refer to NHPCT/Section Q Reference Manual for Nursing Facility Transition Program description/ details.
4. If transition to community is possible and the resident is willing and motivated to engage in the Nursing Facility Transition Program process with their coordinator, GSIL will participate in conversation with the SLRC, resident and family (circle of support), and NF to support care planning
5. Reports on results of referrals and transitions to SLRC and BEAS.
6. Adheres to confidentiality and Health Insurance Portability and Accountability Act requirements.
7. Participates in available training pertaining to the *NHPCT/Section Q Referral Process for New Hampshire.

***Nursing Home Transition to Person-Centered Transition to Community Living**